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Teenage pregnancy prevention: The church, community, culture and contraceptives

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Abstract

It is important to prevent teenage pregnancies to enhance their health, educational level and economic prospects. Peer education should be explored as a strategy to prevent teenage pregnancies. The purpose of this paper is to share the perceptions of peer educators who underwent a peer education-training programme and the effect it had on their own sexual behaviour. A qualitative descriptive, explorative and contextual research design was conducted, using in-depth interviews from 15 participants to gather data. The findings revealed that participants had positive educational experiences; positive personal growth; and wanted to become mentors for their peers. Despite their increased level of knowledge and positive experiences, some found it difficult to mentor others due to religion, culture as well as the opinion of their parents and community. Peer education will only have an effect on contraceptives if the church, the community, diverse cultural norms and traditions are included in the dialogue about contraception. *(Afr J Reprod Health 2021; 25[6]: 51-57).*

Keywords: Peer education, teenage pregnancy, contraceptive use, culture, church, community

Résumé

Il est important de prévenir les grossesses chez les adolescentes pour améliorer leur santé, leur niveau d'éducation et leurs perspectives économiques. L'éducation par les pairs devrait être explorée comme stratégie de prévention des grossesses chez les adolescentes. Le but de cet article est de partager les perceptions des éducateurs pairs qui ont suivi un programme d'éducation-formation par les pairs et l'effet qu'il a eu sur leur propre comportement sexuel. Une conception de recherche qualitative descriptive, exploratoire et contextuelle a été menée, en utilisant des entretiens approfondis avec 15 participants pour recueillir des données. Les résultats ont révélé que les participants avaient des expériences éducatives positives; croissance personnelle positive; et voulaient devenir des mentors pour leurs pairs. Malgré leur niveau accru de connaissances et d'expériences positives, certains ont eu du mal à encadrer d'autres en raison de la religion, de la culture ainsi que de l'opinion de leurs parents et de leur communauté. L'éducation par les pairs n'aura d'effet sur les contraceptifs que si l'église, la communauté, les diverses normes et traditions culturelles sont incluses dans le dialogue sur la contraception. *(Afr J Reprod Health 2021; 25[6]: 51-57).*

Mots-clés: Éducation par les pairs, grossesse chez les adolescentes, utilisation de contraceptifs, culture, église, communauté

Introduction

Substantial numbers of young people in sub-Saharan Africa and elsewhere are sexually active and the teenage pregnancy rate is a concern[1]. In Africa about 18,8% and in sub-Saharan Africa 19,3% of women aged 13-19 years are either pregnant or already have a child[2]. These statistics are of concern since complications resulting from pregnancy and childbirth are the leading cause of maternal mortality in women between the age of 15 and 19[3]. Peer education is one strategy to deal with teenage pregnancy prevention and sexual health promotion, because the peer educators and their peers (teens) can mutually identify with one another as individuals and members of a similar socio-cultural reality. Teens come from diverse religious backgrounds, cultural traditions, ethnic histories and traditions with community leaders and elders that may strongly influence attitudes towards contraceptive use[4]. It is therefore important to understand the context in which cultural-sensitive dialogue needs to occur; thus religion (in this context referred to as the **c**hurch); the role of **c**ommunity leaders and traditions need to be understood. Social media and teen

magazines[5] also discuss sexual issues that may have an influence on the sexual behaviour of teenagers, be it positive or negative.

In reaction to the increase in teenage pregnancies in a country like Cameroon, the government has started the "100% Young" peer education programme to deal with health issues that affect teens, such as sexually transmitted infections and pregnancy prevention[6]. The "100% Young" programme involves teenagers in the age group of 13-19 years and tend to follow the peer leader's model.

The aim of this article is therefore to share the perceptions of peer educators regarding the programme; and how it influenced their own sexual behaviour within a diverse cultural and religious context.

Methods

A qualitative descriptive design was utilised to describe life experiences of peer educators who underwent the peer education programme and give them meaning. The participants were able to express their perceptions, when probed and encouraged by the interviewer[7]. In-depth interviews were conducted, allowing the interviewer to deeply explore the participant's perspectives and opinions.

Population and unit of analysis

The population consisted of 50 peer educators who had already undergone "100% Young" training in Cameroon. The gatekeeper ensured voluntary participation by providing a recruitment letter with all the information on the study and their right not to participate to eligible participants and their parents. An information leaflet and consent form were sent to participants and to the parents of those under 18 years who met the following criteria:

1. Between 13 and 19 years old
2. Involved as peer educators for more than 6 months
3. Unmarried
4. French or English literate

Signed consent forms of the 20 volunteers were provided to the researcher who made an appointment with them to meet at a venue agreed on. The sample size was determined by saturation and 15 in-depth interviews were transcribed and analysed.

Public and patient involvement

Peer educators who previously underwent the program were actively involved in the recruitment of participants. The final reports were shared with the peer educators who partake in the program and are available to any participant on request.

Data gathering

After ethical approval had been obtained from the Research Ethics Committee of the custodian university and from the manager of the "100% Young" training programme, data gathering commenced. The interviews were conducted in a private and relaxed area familiar to the participants and they were asked to give their consent for the interviews to be tape-recorded prior to commencing with the interviews.

The questions asked were:

- Describe how you perceived the peer education training that you underwent.
- Describe how this training affected your own sexual behaviour.

Data analysis

A verbatim transcript, with field notes and non-verbal communications incorporated, was drawn up immediately after every interview. A thematic analysis, using the eight steps described by Tesch in Creswell, were used to analyse the data[8]. The narratives were read several times, gaining an understanding of the content. Similar ideas were grouped together to identify the themes, categories and sub-themes. The direct words of participants were used as sub-themes to indicate the real verbatim data.

Trustworthiness

The four constructs that accurately reflect the assumptions of the qualitative paradigm, namely credibility, transferability, dependability and conformability were adhered to as described by Polit and Beck[9]. The study context was described

in detail and a complete data trail were provided to enhance the trustworthiness of both the research process and findings and to allow for transferability of the findings to similar context.

Results

Ten females and five males participated and were interviewed; seven peer educators were from urban and eight from rural areas. Their ages ranged between 13 and 19 years, with an average age of 16 years. The lowest academic achievement of the participants was Grade 8 and two participants were enrolled at a university. Four themes were identified from the verbatim transcripts (see Table 1). One direct quote per category (see Table 1) are indicative of how the categories and themes emanated.

Discussion

Peer educators emphasised a very positive educational experience and wanted to "*be [role models] for their peers*", they felt empowered and "*cannot wait to share [their] knowledge",* but they also found the influence of the church or religion, the culture and the community challenging.

Positive educational experience

Teens have a positive perception of their risk behaviour if their peers, due to the horizontal and participatory approach to learning, deliver the message[10]. However, peer educational programmes must contain **theoretical knowledge to** empower them to be less dependent on others for information. This empowerment may lead to young people postponing marriage and engaging in sexual relationships later in life [11], eventually changing the socio-economic status of teenagers [12], enabling them to plan their behaviour and make informed choices: *"I can choose who and when to have sex without fear of being pregnant or having STD, for the first time in my life I feel that I am in control"*.

They were provided with the correct information about the ***anatomy and the physiology*** of the reproductive organs including the menstrual cycle: *"I know now when it is a safe time to have sex, and the fertility time"*. Theoretical knowledge about reproduction and the physiology of the male and female reproductive systems and organs is needed[13], because decisions to become sexually active or pregnant must be an informed choice for which ***knowledge of family planning*** is essential: *"I have learned the whole physical aspect of the male and female body, ovulation and menstruation"*.

Knowledge on the effective methods of contraception is needed to prevent pregnancy ***and sexually transmitted infections,*** such as HIV, was perceived as positive: *"I know now how to use condoms if we want to escape unwanted pregnancies"*.

Positive personal growth

Positive personal growth, thus the impact of stretching, learning, growing and applying personal knowledge and other people's experiences in order to change for the better[14] were emphasised by participants: *"Skills in communication and organisation, training in facilitation and leadership, teaching experience and counselling are just some of the benefits that I gained from the '100% Young' training programme"*. They were confident that the programme gave them back their ***self-respect:*** *"I have my self-respect back?*

Peer pressure is widely recognised as a major contributor to risky sexual behaviour; and teens need to be assertive and ***empowered*** if their voices are to be heard. They confirmed that they experienced empowerment:

"I have the power to make my own decisions"
"Actually I know my right as a teen…the programme empowered me with the right answer..."

They voiced that they obtained ***negotiation skills*** by means of which conflict and disagreement could be prevented, and agreements reached[15]: *"I can negotiate when to have fun, sex, or go to a movie".*

Sexual ***behaviour change*** to prevent HIV, sexually transmitted diseases and unwanted pregnancy is difficult[16]; and some participants did not express any change in their behaviour as evidenced by one participant: *"If my partner is looking beautiful and healthy, there is no method used…even any HIV test is done, we check with our eyes…"*.

Table 1: Categories, themes and sub-themes

Themes	Categories	Sub-themes
Positive educational experience	Knowledge of:	*"I know now how my body works."*
	Anatomy and physiology	*"I have learnt about ovulation and menstruation"*
	Family planning	*"I know to use condoms if we want to escape unwanted pregnancies."*
		"I have learnt different contraceptive methods"
	Implications of teen pregnancy	*"Having a baby is life changing."*
		"Being a mom is a full time job"
	Prevention of sexually transmitted diseases	*"I learnt how to prevent against sexually transmitted disease and HIV/AIDS."*
		"I learnt about sexually transmitted diseases now"
Positive personal growth	Self-respect	*"I have my self-esteem back."*
		"I am better alone than a boyfriend who does not respect me"
	Empowerment	*"I can say no to sex."*
		"I have the power to make my own decisions"
	Negotiation skills	*"I can negotiate when to have fun, sex or go to a movie."*
		"I learnt about sex negotiation"
	Behaviour change	*"I adopted healthy sexual behaviour."*
		"I am on top of this sexual game"
Mentoring role	Shared experience and knowledge	*"I want to be a role model for my peers."*
		"I want to share my knowledge"
Challenges to contraceptive use	Attitude of nursing staff	*"At the clinic it is worse there is no privacy, the nurses are rude and chase us."*
		"The nurse gets worried that you have to much sex and can tell your parent"
	Accessibility of contraceptives	*"Contraceptives are expensive…. sometimes the clinic is out of stock …it is very expensive."*
		"It is not easy to get contraceptives"
	Gender inequalities	*"If I ever find my girl using the family planning it is over…"*
		"I am scared to talk to my boyfriend about condoms"
	Misconceptions	*"the pill van make you too weak to focus……it is safer to get pregnant"*
		"Pills, condoms, injections, all are dangerous"
	Socio-cultural expectations	*"The pastor in our church emphasises that family planning methods is killing, it is a big sin in front of God."*
		"My parents and the elders are against contraceptives"

Other participants took the information at heart and changed their behaviour: *"I adopted healthy sexual behaviour"*. Teens are more likely to ask questions about sexual health from peers whom they perceive as having a better understanding[17]; thus seeing them as their ***mentors***.

Mentoring role

Peer educators, as mentors, wanted to share ` the information with their peers and provide guidance, motivation and emotional support: *"I want to be a role model for my peers"*

Challenges that influence contraceptive use

Teenagers worldwide are sexually active and they are not using contraceptives or any protection against sexually transmitted infection[1]. Five categories were identified that are challenging to contraceptive use: (1) the attitudes of nursing staff, (2) gender inequalities, (3) accessibility of contraceptives (4) misconceptions and (5) socio-cultural expectations.

Paternalistic judgmental views or the ***attitudes by contraceptive service providers***, coupled with a

lack of privacy and confidentiality, were said to inhibit teens from seeking contraceptive services. Some providers do not maintain confidentiality and give information to their parents: *"If you come for condoms often at the health clinic, the nurse gets worried that you are having too much sex and can tell your parents"*.

Contraceptives are sometimes unavailable at clinics; or only the high cost choices are available, particularly in rural areas[18]. One participant observed the following: *"Contraceptives are expensive…people are too poor here…sometimes the clinic is out of stock you have to spend on transport to town…."* Many teens do not use contraceptives because of ***gender inequalities***[19]. Girls reported a lack of power as a key obstacle to contraceptive use similar to that of adult women due to their ***religion*** (church denominations), ***cultural norms*** (traditionalists), ***beliefs*** and ethnicity[20] and the role of male partners in decision-making. One participant indicated the following: "*If I ever find my girl using family planning it is over…?"*

Teens have various beliefs and ***misconceptions*** about contraceptives. They believe that contraceptives interfere with fertility; the pill will burn their eggs and will accumulate in the body to cause fibroids, cancer, and abortions[21]: *"I don't like anything, pills condoms, injections, all are dangerous. They go through the tube where eggs come from. When they arrive in the middle of the eggs, they burn them all".* One participant reported that when trying to share her new knowledge she was told: *"the pill can make you too weak to focus, for me it is safer to just get pregnant".*

Peer pressure, social media and messages through teen magazines also influence decision-making. The `hook-up` culture described in teen magazines limits knowledge about culture variations and opinions about casual or emotional encounters and contraceptives relevance[5]. Teens often indicate that young women who look healthy do not need contraception[22]. *"If my partner is looking beautiful and healthy, there is no method used…even any HIV test is done, we check with our eyes…."*. Male participants felt that their peers prefer sex without a condom as they claim that: *"They cannot eat a sweet in plastic wrapping"*.

Another challenge perceived by participants was ***socio-cultural expectations***. In African society, the purpose of women is to bear a child; however, traditional norms prohibit sexual activity and pregnancy[23]. ***Cultural*** norms condemn parents talking with their children about sex and the use of contraceptives:

"In my community my parents and elders are against contraceptives. If they find you with a condom, they lose confidence in you".

Furthermore, the values in some ***African traditions*** (cultures); the influence of the community leaders and ***diverse church denominations*** (religion) do not support the use of contraceptives[20]. Religion plays a pivotal role since religious values shape and regulate individual behaviour[24]. Often parents use scare tactics to keep their children from using contraceptives but they also do not want their teenagers to become pregnant[25]. *"My parents were shocked when I asked them about sexuality. My mum told me that children do not talk about those things, especially when you are single"*.

The key challenges to the use of contraceptives, as identified by participants, are supported by literature. Contradictory messages from health workers, male partners, parents, teachers and their cultural or community leaders[26] influence decision-making. Women do not use contraceptives due to their cultural and community values and norms, church affiliations (religion) and traditions that many times prohibit independent decision- making. Participants believed that the churches largely added to confusion about contradictory information. The participants said that some churches are pro pregnancy: *"The pastor in our church emphasises that the use of family planning methods is killing, it is a big sin in front of God"*.

The ***community*** links the use of contraceptives to promiscuity, prostitution, and future infertility[27]. In sub-Saharan African countries, early pregnancy is often seen as a blessing since it is proof of young woman's fertility[28]. A participant stated that the common responses from teens while educating them were as follows: *"School and money don't talk to you…children bring you the entire joy in*

life; trust me…?" This perception poses a major challenge to the peer educators in the "100% young" training programme.

Ethics statement

Institutional approval was obtained from the Health Research Ethics Committee (HSHDC/174/2013) at the custodian university and from the manager of the "100% Young" training programme. Participants over the age of 18 signed informed consent forms and parental consent was obtained from those participants between 13 and 17 where after the participants themselves provided assent. All aspects pertaining to privacy, anonymity, confidentiality, and freedom from harm, as described by Polit and Beck, were considered[9]. The names of participants were not indicated, the transcripts were stored on a password protected computer, the tape recordings were saved in a locked cabinet with access only by the researchers and all the information provided by participants were kept confidential.

Conclusion

The "100% young" training programme dealt with key empowerment dimensions because empowerment is urgently required if the contraceptive needs of the teenagers are to be solved[29] and unwanted pregnancies prevented, but the socio-cultural norms remain a challenge. High fertility, unwanted pregnancies and unsafe induced abortions that are associated with high morbidity and mortality among teenagers, specifically in sub-Saharan Africa, are a public health concern[20]. Reducing challenges; eradicating misconceptions; and involving the community and religious leaders through peer education have the potential to improve contraceptive use, thereby reducing unwanted teenage pregnancies. Peer educators experienced it positively; however, the participants were concerned about several young people, communities, religious leaders, and their parents who still regard contraceptives as taboo, affecting the independent choice of young women. Ignorance and failed communication, coupled with persistent religious, cultural, and social values, thus play an important role in the decision not to use contraceptives:

"The influence of the church (religion), ethnicity and culture as well as community leaders that support traditional and cultural values are affecting the choice of women and teenagers in the use of contraceptives and cannot be underestimated" (authors).

Teenage pregnancy is a reality; the sad fact is that this reality has been ongoing for decades and frequently results in unfulfilled potential and perpetuates the cycles of unemployment and poverty.

Contribution of authors

Both authors participated in the conceiving and designing of the study. The second author collected and analysed the data. The first author guided the data gathering process, co-coded the data and prepared the manuscript. Both authors approve of the manuscript.

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